



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DEC OF TEXAS, INC
601 TEXAN TRAIL, STE 201
CORPUS CHRISTI, TX 78411

Respondent Name

ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-10-4546-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary from Table of Disputed Services: "Treating Doctor, Edwin Melendez, MD referred this claimant for MMI & IR I personally spoke to adjuster, Dale Pigg on 8-28-09 and this was authorized. I have submitted the bill 3 separate times to no avail. Then auditing co. is denying payment stating that my office did not submit bill within the 95 day filing period. On 5/20/10 I faxed a fax confirmation showing that my office faxed the bill to the adjuster on 9-17-09 well within the filing period. I was advised today that my request for reconsideration was denied again."

Amount in Dispute: \$650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response.

Response Submitted by: N/A

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
09/08/2009	99456-WP	\$650.00	\$650.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.

3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. 28 Texas Administrative Code §134.204 sets out the guidelines for reimbursement of Workers' Compensation specific services.
5. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
6. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits dated May 27, 2010
 - 29-The time limit for filling has expired.

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.027 and 28 Texas Administrative Code §102.4?
3. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to 28 Texas Administrative Code §133.20(b) states in pertinent part "Except as provided in Texas Labor code §408.0272...a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that Texas Labor Code §408.0272 applies to the service in dispute. For that reason, the requestor in this dispute was required to send the medical bill no later than 95 days after the service in dispute was provided. 28 Texas Administrative Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus 5 days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
2. Review of the documentation submitted by the requestor finds medical bills with printed date September 17, 2009, a fax transaction report dated 09/17/2009, two email confirmation pages dated December 17, 2009 & March 24, 2010 and an Explanation of Benefits dated, May 27, 2010. Per 28 Texas Administrative Code §102.4(h), documentation submitted by the requestor in this medical fee dispute supports that a medical bill was submitted for payment to the insurance carrier within 95 days after the date on which the health care services were provided to the injured employee.
3. In accordance with Texas Labor Code §408.027, the Requestor has timely submitted bill to the respondent. The requestor's documentation supports the services rendered. Therefore, reimbursement is recommended per 28 Texas Administrative Code §134.204 as follows:
\$350 for the billing and reimbursement of an MMI evaluation per 28 Texas Administrative Code §134.204 (j)(3)(C) and \$300 for range of motion testing, hand (upper extremity) per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II) for a total reimbursement of \$650.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$650.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$650.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

01/30/2012

Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.